STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265663	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Nursing & Rehab	1510 Bluff Street Fulton, MO 65251

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 43327 Based on observation, interview, and record review, facility staff failed to ensure three most recent years of survey results were posted and readily accessible to residents, family member or representatives of residents. The facility census was 44. 1. Review of the facility's policies showed staff did not provide a policy for required postings or survey posting. 2. Observation on 04/29/24 at 9:59 P.M., showed the facility did not have a copy of the federal survey results accessible to the resident, family members, or representatives of residents. 3. Observation on 04/30/24 at 7:48 A.M., showed the facility did not have a copy of the federal survey results accessible to the resident, family members, or representatives of residents. 4. Observation on 05/01/24 at 3:40 P.M., showed the facility did not have a copy of the federal survey results accessible to the residents, family members, or representatives of residents. 5. During an interview on 05/02/24 at 8:42 A.M., Licensed Practical Nurse (LPN) F said he/she is not sure where the survey is posted. During an interview on 05/01/24 at 3:43 P.M., the administrator said the past survey results should be on the shelf by the front entrance door. It was there but we now don't know where it is at and are looking for it.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 42484 Based on observation, interview and record review, facility staff failed to ensure resident's personal information was protected when staff left residents' Electronic Health Records (EHR) open and unattended in public hallways. The facility census was 44. 1. Review of the facility's Medication Administration Guidelines, undated, showed the record did not contain direction for protection of residents' privacy. 2. Observation on 04/30/24 at 8:49 A.M., showed Certified Medical Technician (CMT) A left the EHR screen with resident information on the screen unlocked in the hallway when he/she administered to a resident in their room. Observation on 04/30/24 at 8:51 A.M., showed CMT A left the EHR screen unlocked in the hallway with resident information on the screen when he/she adminsitered medication to a resident in their room. Observation on 04/30/24 at 9:05A.M., showed CMT A left the EHR screen unlocked in the hallway with resident information on the screen when he/she administered medication to a resident in their room. An unsecured box with drawers containing residents' medications was left on the medication cart. Observation on 04/30/24 at 9:40 A.M., showed Certified Nursing Assistant (CNA) G and Registered Nurse (RN) F left the EHR screen unlocked in the hallway with resident information on the screen when he/she administered medication to a resident with their backs turned in the television room. During an interview on 04/30/24 at 09:40 A.M., RN F said the EHR screens should always be locked while the medication cart is unattended. During an interview on 05/02/24 at 10:23 A.M., the Director of Nursing (DON) said all computers should have screens locked when unattended. If left open the residents' right for privacy would be violated. During an interview on 05/02/24 at 11:12 A.M., the administrator said the computer screens on medication carts should always be down to protect residents' privacy. During an interview on 05/14/24 at 2:30 P.M., CMT A said the screens on the carts should be locked when unattended to provide privacy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interview and record review, facility staff failed to provide a comfortable and homelike environment for residents, when staff failed to maintain bathroom doorframes, sink counters, and floors in good repair. The facility census was 44. 1. Review of the facility's policies showed staff did not provide a policy regarding environment. Review of the facility's housekeeper job description, dated May, 2006, showed housekeeping staff expectations include: - Clean floors, to include sweeping, dusting, damp/wet mopping, stripping, waxing, buffing, disinfection, etc; - Clean, wash, sanitize, and polish bathroom fixtures, ensure that water marks are removed from fixtures. Review of the facility's maintenance manager job description, dated May 2006, showed maintenance staff performs minor plumbing repairs, including unplugging, repairing, and replacing toilets, lavatories, and sinks and replacing faulty gate and ball valves. 2. Observation on 04/29/24 at 7:45 P.M., showed resident occupied room [ROOM NUMBER]'s bathroom toilet base contained brown and the sink counter broken not secured with a piece of the top missing. Observation on 04/29/24 at 7:45 P.M., showed resident occupied room [ROOM NUMBER] floor tiles in the bathroom and living area with brown stains. Observation on 04/29/24 at 7:49 P.M., showed resident occupied room [ROOM NUMBER] the bathroom floor with [NAME] stains. Observation on 04/29/24 at 8:00 P.M. showed resident occupied room [ROOM NUMBER] floor tiles with streaks of brown throughout the entire room. Observation on 04/29/24 at 08:27 P.M., showed resident occupied room [ROOM NUMBER]'s bathroom countertop with white/tan discoloration areas and the base of the toilet floor tiles with dark yellow and rust colored stains. Observation on 04/30/24 at 8:30 A.M., showed resident occupied room [ROOM NUMBER] bathroom tiles with dark stains around the toilet and floor tiles. Observation showed the bathroom door frame rusted and rough to the touch. Observation on 04/30/24 at 8:40 A.M., showed resident occupied room [ROOM NUMBER] with heavily stained flooring tiles around the toilet base. Metal door frames in the bathroom were rusted at the base. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/30/24 at 9:00 A.M., showed resident occupied room [ROOM NUMBER] bathroom with stained floors around the toilet base and excessive amounts of caulking around the toilet base. 3. During an interview on 05/02/24 at 8:10 A.M., housekeeper C said we clean the residents bathrooms daily. We are aware of the floors needing to be repaired. Maintenance has been told about the damage but has not repaired it. During an interview on 05/02/24 at 8:20 A.M., Maintenance D said he/she was aware of the damage in the bathroom and a list of repairs needed has been made. He/She said they were not aware of the rusted door frames. During an interview on 05/02/24 at 9:00 A.M., Certified Nurse Aid E said we tell housekeeping if an area needs to be cleaned. He/She said if there is damage in a room or anywhere, we tell the charge nurse or maintenance directly. During an interview on 05/02/24 at 9:21 A.M., the maintenance director said we do every day preventative maintenance or staff tell us about what repairs are needed. We are aware of the damaged bathrooms but are having trouble getting support to pay for the materials needed to repair the damage. During an interview on 05/02/24 at 10:40 A.M., the Director of Nursing said maintenance is responsible for repairs in the facility. If there is damage it should be repaired quickly.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Based on interview and record review, facility staff failed to provide written information of the facility's bed hold policy at the time of transfer to the hospital to the resident and/or resident's representative for three residents (Residents #14, #24, and #45) out of three sampled residents who were discharged to the hospital. The facility census was 44. 1. Review of the facility's Bed Hold Guidelines, undated, showed the facility will notify all residents and/or their representative of the bed hold guidelines. This notification shall be given at the time of transfer to the hospital. 2. Review of Resident #14's medical record showed: -Transferred to the hospital on 02/14/24 and returned on 03/28/24; -Did not contain documentation staff notified the resident or the resident's representative of the facility's bed hold policy at time of discharge. 3. Review of Resident #24's medical record showed: -Transferred to the hospital on 04/02/24 and returned on 04/09/24; -Did not contain documentation staff notified the resident or the resident's representative of the facility's bed hold policy at time of discharge. 4. Review of Resident #45's medical record showed: -Transferred to the hospital on 04/23/24 and still hospitalized on [DATE]; -Did not contain documentation staff notified the resident or the resident's representative of the facility's bed hold policy at time of discharge. 5. During an interview on 05/02/24 at 8:33 A.M., the administrator said the charge nurse is responsible to complete bed holds when the resident is discharged to the hospital. He/She believed the licensed nursing staff were not aware they needed to be completed. During an interview on 05/02/24 at 8:42 A.M., Licensed Practical Nurse (LPN) F said bed holds should be given to the resident if sent to the hospital by the nurses. He/She said he/she cannot answer why the bed hold were not completed. During an interview on 05/02/24 at 10:23 A.M., the Director of Nursing (DON) said he/she is new to the position and knows there is a form to complete but is not sure who is responsible to complete them.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 42484 Based on interview and record review, facility staff failed to complete the required Comprehensive Minimum Data Set (MDS), a federally mandated resident assessment, within the required timeframe for two (Residents #1, and #3) out of two sampled residents The facility census was 44. 1. Review of the facility's Minimum Data Set (MDS) and Care Planning guidelines, dated September 2013, showed it is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) manual, and any published interim RAI manual errata documents, as the authoritative guide for completion of the MDS and establishing and maintaining resident care plans. Review of the Resident Assessment Instrument (RAI) manual version 3.0 RAI, dated October 2023, Omnibus Budget Reconciliation Act (OBRA)-required Assessment Summary showed assessment time frames as follows: -Admission (Comprehensive) MDS completion date no later than 14th calendar day of the resident's admission and submitted no later than 14 calendar days from the care plan completion date; -Annual (Comprehensive) MDS completion date no later than Assessment Reference Date (ARD) of previous comprehensive + 366 calendar days or 92 days following the previous OBRA quarterly assessment and submitted no later than 14 calendar days from the care plan completion date. 2. Review of Resident #1's medical record showed the MDS assessments did not contain a completed Annual comprehensive assessment on or before 2/23/24. 3. Review of Resident #3's medical record showed the MDS assessments did not contain a completed Annual comprehensive assessment on or before 03/19/24. 4. During an interview on 05/01/24 at 10:16 A.M., the administrator said the facility does not currently have a full-time MDS nurse. He/She said there is a floor nurse lined up for the position when a floor nurse position is filled. He/She said a nurse from the corporate office is trying to fill in between their other duties. During an interview on 05/2/24 at 10:23 A.M., the Director of Nursing (DON) said he/she is new and not familiar with the MDS process. He/She said when the MDS position is filled full time, the MDS nurse will be trained by the corporate nurse. During an interview on 05/02/24 at 11:14 A.M, the administrator said the corporate nurse and the DON will help get the MDS assessments completed until the floor nurse can fill the role full time. He/She said the staff should use the RAI manual as a guide to complete and submit the MDS data timely.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Based on observation, interview and record review, facility staff failed to perform a significant change in status Minimum Data Set (MDS) assessment, a federally mandated assessment tool, for one (Resident #37) of one resident who elected hospice and one (Resident #14) of six sampled residents who had a decline in their ability to feed self with supervision, transfer with substantial/maximum assistance and perform toilet hygiene. The facility census was 44. 1. Review of the facility's MDS and Care Planning guidelines, dated September 2013, showed it is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) manual, and any published interim RAI manual errata documents, as the authoritative guide for completion of the MDS and establishing and maintaining resident care plans. Review of the RAI manual version 3.0 RAI, dated October 2023, Omnibus Budget Reconcilliation Act (OBRA)-required Assessment Summary showed assessment time frames as follows: -A significant change in status assessment (SCSA) is appropriate when there is a determination that significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent quarterly assessments and the resident's condition is not expected to return to baseline in two weeks; -A significant change is any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning; -A significant change assessment must be completed within 14 days a determination has been made that a significant change in status has occurred and submitted within 14 days of the care plan completion date. -A SCSA is appropriate when There is a determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments and the resident's condition is not expected to return to baseline within two weeks. -A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The (Assessment Reference Date) ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. 2. Review of Resident #14's Quarterly MDS, dated [DATE], showed staff assessed the resident as: (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cognitively impaired; -Required supervision from staff for eating, oral hygiene, and personal hygiene; -Required substantial/maximum assistance from staff for toilet hygiene, shower/bath, dressing of upper and lower extremities, sitting to lying, lying to sitting, sitting to standing, chair/bed to chair transfers, toilet transfers and tub/shower transfers; -Coughed or choked during meals or when swallowing medication; -Received a regular diet; -Diagnosis of dementia. Review of the resident's medical record showed: -The resident was discharged to the hospital on 02/14/24 and returned to the facility on [DATE]; -A physician order, dated 03/28/24 for nothing by mouth (NPO); -A physician order, dated 03/29/24 for Jevity (a type of artificial nutrition) 1.2 calorie, 300 milliliter (mL) bolus per gastric tube (tube placed into the stomach as a means to infuse food/fluids) four times a day ; -All oral medications ordered to be given by gastric tube; -The record did not contain a completed/submitted SCSA when the resident stopped eating and had a decline in ability to transfer and perform toilet hygiene. Observation on 04/29/24 at 7:40 P.M., showed the resident in bed with a gastric tube syringe and flush container on the overbed table. Observation on 04/30/24 at 8:47 A.M., showed the resident in bed with a gastric tube syringe and flush container on the overbed table. Observation on 05/01/24 at 2:00 P.M., showed Certified Nurse Aide (CNA) E and CNA H use a mechanical lift to transfer the resident to bed and provide incontinence care to the resident. The resident was dependent on staff for the transfer and hygiene. Observation on 05/01/24 at 02:35 P.M., showed Licensed Practical Nurse (LPN) I administered a bolus of Jevity 1.2 calorie nutrition to the resident by gastric tube. 3. Review of Resident #37's Quarterly MDS dated [DATE] showed staff assessed the resident as: -Cognitively impaired; -Diagnosis of dementia and stroke; (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Did not use hospice services. Review of the resident's medical record showed: -admitted to hospice on 02/26/24; -The record did not contain an order for hospice, a care plan for hospice, or a completed/submitted significant change of status when the resident and/or representative elected hospice services. 4. During an interview on 5/01/24 at 10:16 A.M., the administrator said the facility does not currently have a full-time MDS nurse. He/She said there is a floor nurse lined up for the position when a floor nurse postion is filled. He/She said a nurse from the corporate office is trying to fill in between their other duties. During an interview on 05/02/24 at 10:23 A.M., the Director of Nursing (DON) said he/she is new and not familiar with the MDS process. He/She said when the MDS position is filled full time, the MDS nurse will be trained by the corporate nurse. During an interview on 05/02/24 at 11:14 A.M, the administrator said the staff shoud use the RAI manual as a guide to complete and submit the MDS data timely.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Based on interview and record review, facility staff failed to complete the required Quarterly Minimum Data Set (MDS), a federally mandated resident assessment, within the required timeframe for two of four (Resident #18 and #30) sampled residents. The facility census was 44. 1. Review of the facility's MDS and Care Planning guidelines, dated September 2013, showed it is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) manual, and any published interim RAI manual errata documents, as the authoritative guide for completion of the MDS and establishing and maintaining resident care plans. Review of the RAI manual version 3.0 RAI, dated October 2023, Omnibus Budget Reconcilliation Act (OBRA)-required Assessment Summary showed assessment time frames as follows: -Quarterly (Non-Comprehensive) MDS completion date not later than Assessment Reference Date (ARD) + 14 calendar days; -Quarterly assessment for a resident must be completed at least evbery 92 days following the previous OBRA assessment of any type. 2. Review of Resident #18's medical record showed the following MDS assessments: -Annual comprehensive MDS, dated [DATE], as production accepted; -Quarterly MDS dated [DATE] as production accepted; -The record did not contain a completed Quarterly assessment on or before 2/21/24. 3. Review of Resident #30's medical record showed the following MDS assessments: -Annual comprehensive MDS, dated [DATE], as production accepted; -The record did not contain a completed Quarterly assessment on or before 03/01/24. 4. During an interview on 05/01/24 at 10:16 A.M., the administrator said the facility does not currently have a full-time MDS nurse. He/She said there is a floor nurse lined up for the position when a floor nurse postion is filled. He/She said a nurse from the corporate office is trying to fill in between their other duties. During an interview on 05/02/24 at 10:23 A.M., the Director of Nursing (DON) said he/she is new and not familiar with the MDS process. He/She said when the MDS position is filled full time, the MDS nurse will be trained by the corporate nurse. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/02/24 at 11:14 A.M, the administrator said the corporate nurse and the DON will help get the MDS assessments completed until the floor nurse can fill the role full time. He/She said the staff shoud use the RAI manual as a guide to complete and submit the MDS data timely.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42484 Based on interview and record review, facility staff failed to correctly assess one resident (Resident #2) who received an anticoagulant (a blood thinning medication used to treat and prevent blood clots and to prevent stroke in people with atrial fibrillation medication) and failed to assess one resident (Resident #12) for their preferences and oral/dental status. The facility census was 44. 1. Review of the facility's Minimum Data Set (MDS) and Care Planning guidelines, dated September 2013, showed it is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) manual, and any published interim RAI manual errata documents, as the authoritative guide for completion of the MDS and establishing and maintaining resident care plans. Review of the Resident Assessment Instrument (RAI) manual version 3.0 RAI, dated October 2023, Omnibus Budget Reconciliation Act (OBRA)-required Assessment Summary, Section N, showed instruction for anticoagulant coding as follows: -In circumstances where reference materials vary in identifying a medication's therapeutic category and/or pharmacological classification, consult the resources/links cited in this section or consult the medication package insert, which is available through the facility's pharmacy or the manufacturer's website. If necessary, request input from the consulting pharmacist. -The reference material says -Apixaban (an anticoagulant withe the brand name of Eliquis) is a novel oral anticoagulant (NOAC) approved by the US Food and Drug Administration (FDA) in 2012. -Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs) which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant. 2. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Took high risk medication categories of antipsychotic, antidepressant, antianxiety, and diuretic (a medication to help reduce fluid buildup in the body, commonly referred to as a water pill). -Diagnosis of atrial fibrillation. Review of the resident's physician order sheet, dated April 2024, showed an order for 5 milligrams (mg) of Eliquis, one tablet twice a day beginning 01/08/24. The MDS did not indicate the resident took a high-risk medication under the category of anti-coagulant. 3. Review of Resident #12's Quarterly Minimum Data Set, dated dated [DATE], showed staff did not assess sections: Section F - Preferences for Customary Routine and Activities; Section L - Oral/Dental Status. (continued on next page)

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	265663	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Nursing & Rehab	1510 Bluff Street Fulton, MO 65251

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an interview on 5/1/24 at 10:16 A.M., the administrator said the facility does not currently have a full-time MDS nurse. He/She said there is a floor nurse lined up for the position when a floor nurse position is filled. He/She said a nurse from the corporate office is trying to fill in between their other duties. During an interview on 05/2/24 at 10:23 A.M., the Director of Nursing (DON) said he/she is new and not familiar with the MDS process. He/She said when the MDS position is filled full time, the MDS nurse will be trained by the corporate nurse. During an interview on 05/02/24 at 11:14 A.M, the administrator said the corporate nurse and the DON will help get the MDS assessments completed until the floor nurse can fill the role full time. He/She said the staff should use the RAI manual as a guide to complete and submit the MDS data timely.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43327 Based on observation, interview and record review, facility staff failed to develop a comprehensive person-centered care plan for each resident to meet the resident's medical and nursing needs for four (Resident #14, #20, #35, and #37) of six sampled residents. The facility census was 44. 1. Review of the facility's Minimum Data Set (MDS) and Care Planning guidelines, dated September 2013, showed it is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI) manual, and any published interim RAI manual errata documents, as the authoritative guide for completion of the MDS and establishing and maintaining resident care plans. Review of the Resident Assessment Instrument (RAI) manual version 3.0 RAI, dated October 2023, showed: -Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; -the resident's care plan must be reviewed after each assessment, as required by S483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions; -Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan; -Facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI including monitoring each resident's condition and responding with appropriate interventions; -The comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 2. Review of Resident #14's Quarterly MDS, dated [DATE], showed staff assessed the resident as; -Cognitively impaired; -Required supervision from staff for eating, oral hygiene and personal hygiene; -Required substantial/maximum assistance from staff for toilet hygiene, shower/bathing, upper and lower body dressing; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Required substantial/maximum assistance from staff for toilet transfers, tub/shower transfers, chair/bed to chair transfers and sit to stand; -Frequently incontinent of bowel and bladder. Review of the resident's care plan, dated 04/10/24, showed the care plan did not contain updated information related to the resident mode of transfer changed to a mechanical lift, when the resident required more assistance for toileting/toilet hygiene, when the resident diet changed to nothing by mouth or the use of the gastric tube feeding. Review of the resident's Physician Order Sheet (POS), dated 04/01/24 through 05/01/24 showed: -On 03/28/24, Nothing by mouth; -On 03/29/24, Jevity (dietary supplement) 1.2 calorie, 300 milliliters four times a day. Observation on 05/01/24 at 02:00 P.M., showed Certified Nurse Aide (CNA) F and CNA H transfered the resident to bed with use of a mechanical lift, provided total incontence care and dressed the resident. Observation on 05/01/24 at 02:35 P.M., showed Licensed Practical Nurse (LPN) I administered Jevity 1.2 calorie 300 milliliters by gastric tube. 3. Review of Resident #20's Admission MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -History of falls; -Unclear speech; -Sometimes understands, responds adequately to simple, direct communication only; -At risk for developing pressure injury; -On a turn and reposition program; -Communication trigger; -Fall trigger; -Pressure Risk; -Diagnosis of cancer and schizophrenia. Review of the resident's care plan, dated 04/11/24, showed the care plan did not contain direction for risk for falls, risk for pressure injury, nutrition for pressure injury risk, or communication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's nurse notes, dated 04/16/24 at 03:49 P.M., showed the resident was getting out of bed and transferring to the wheelchair and slid off the side of the bed. The resident was assessed and assisted off the floor and to wheelchair. He/She denies pain and no abnormal positioning of the extremities were noted. No reddened areas or bruising noted to the skin. Fall was unwitnessed so a neurological exam was initiated. Review of the resident's Event Report, dated 04/16/24, showed the resident is to be up to wheelchair with assist of one staff. When he/she is up in the wheelchair he/she is to be out in the lobby for supervision. The care plan did not contain direction for fall prevention or updated with the new intervention after the fall. 4. Review of Resident #35's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -No behaviors or rejection of care; -Dependent on staff for personal hygiene; -Impaired functional range of motion in both upper and lower extremities; -Five percent or more of unplanned weight loss; -No specialized diet; -Diagnosis of Dementia. Review of the resident's POS, dated 04/01/24 through 05/01/24 showed: -On 07/03/23, Diet-soft and bite sized with ground meat and nectar thickened liquids; -On 08/14/23, Boost supplement twice a day. Review of the resident's care plan, dated 02/27/24, showed the care plan did not contain direction for facial hair preferences, contracture management, or change to diet and required assistance needed. Observation on 04/29/24 at 7:37 P.M., showed the resident in bed with long facial hair to chin and contractures to both arms and legs. Observation on 04/30/24 at 8:01 A.M. and 10:22 A.M., showed the resident at the nurse station with long facial hair to chin and contractures to both arms and legs. Observation on 04/30/24 at 11:56 A.M., showed the resident in the dining room. Staff fed the resident a ground meat diet with nectar thick liquids. Observation on 05/02/24 at 08:28 A.M., showed the resident at the nurse station with long facial hair to chin and contractures to both arms and legs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #37's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively impaired and diagnosis of adult failure to thrive. Review of the facility's census record, showed the resident admitted to hospice on 02/26/24. Review of the resident's Care plan, dated 04/01/24, showed the care plan did not contain direction for hospice. 6. During an interview on 05/02/24 at 9:00 A.M., LPN I said he/she would be assuming the role of the MDS nurse and would be responsible for completing the care plans. He/She has had the title for two days but has been still helping on the floor until his/her position has been filled. He/She cannot answer for what was or was not completed prior to him/her. During an interview on 05/02/24 at 10:23 A.M., the Director of Nursing (DON) said care plans should be comprehensive and include anything that pertains to the resident by symptoms. He/She said care plans should reflect physician orders, hospice, personal preferences of the resident, contracture management, fall interventions/prevention, skin interventions/prevention, diet and nutrition, and individualized as best as possible. He/She said the care plans are updated as needed but at least quarterly. He/She said nurses and aides have access to the care plans and are a guide to direct care for the resident. During an interview on 05/02/24 at 11:14 A.M., the administrator said the facility uses the RAI manual for direction on completing the MDS and care plans. He/She said the DON and corporate nurse will be completing the assessments and care plans until a replacement can be found for the nurse moving into that position.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, staff interview and record review, facility staff failed to meet professional standards of care when nursing staff did not obtain orders for water for one (Resident #14) out of one resident who received all hydration via gastric tube, failed to complete resident weights for three (Resident #6, #29, and #35) out of twelve sampled residents, failed to obtain wound measurements with weekly skin assessments for one resident (Resident #35) of three sampled residents with wounds. The facility staff document falls and fall follow-up for one (Resident #2) of two sampled residents. The facility census was 44. 1. Review of the facility's Enteral Nutritional Therapy (tube feeding) policy, undated, showed to follow the feeding with the prescribed amount of water. 2. Review of Resident #14's Physician Order Sheet (POS), dated 05/01/24, showed: -On 03/28/24, Nothing by mouth; -On 03/29/24, Gastric feeding of Jevity 1.2 calories (a type of nutrition) 300 milliliters four times a day; -The POS did not contain an order to flush the gastric feeding tube with water or designate an amount to flush with. Observation on 05/01/24 at 02:35 P.M., showed Licensed Practical Nurse (LPN) I adminsitered 60 milliliters of water through the gastric tube, 300 milliliters of Jevity 1.2, followed by 60 milliliters of water. During an interview on 05/01/24 at 2:35 P.M., LPN I said he/she flushes the gastric tube with 60 milliliters of water before and after the feeding with distilled water. He/She said he/she was instructed by a long-standing nurse to flush the gastric tube this way. LPN I said he/she would expect there to be an order to flush the gastric tube but does not know why there is not one. During an interview on 05/02/24 at 10:23 A.M., the Director of Nursing (DON) said if a resident has a gastric tube, there should be an order for water flushes to decrease the potential for dehydration. He/She expects the nurse to call the physician if there is no order in the medical record. He/She was not aware the record did not contain an order. 3. Review of the facility's Weight Monitoring policy, dated May 2015, showed: -In recognition of the fact that large weight variances: particularly weight loss trends, are significant risk factors for the ill and debilitated elderly, this facility will monitor weight changes monthly; -Weight will be obtained on each resident on admission and re-admission from the hospital; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monthly weights for each resident will be completed by the nursing department by the 7th of the month; -A re-weight will be obtained no later than 2 working days for residents that show a significant weight change, under the direction of a licensed nurse; -Weights will be entered into the computer by a designated person in the facility; -New admits and re-admits from the hospital will be weighed weekly for four weeks; -Residents fed per tube will be placed on weekly weights for 4 weekly when their formula has been increased or decreased. Review of the facility's Wound Care and Treatment policy, undated, showed staff are to complete an on-going skin assessment with weekly documentation of status. The policy did not contain description of what to document to include measurements. 4. Review of Resident #6's POS, dated 08/23/23, showed the resident's weight was ordered to be assessed once a week on a Wednesday. Review of the resident's medical record, between 02/14/24 and 05/01/24, showed staff documented the resident's weight on 02/24/24, 03/05/34, and 04/03/24. 5. Review of Resident #29's POS, dated 03/24/23, showed an order for monthly weights. Review of the resident's medical records between 02/14/23 and 05/01/24, showed staff did not document weights for the month of April. 6. Review of Resident #35's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/26/24 showed staff assessed the resident as: -Cognitively impaired; -Presence of Stage III pressure wound (wound extends down under the tissue of the skin) on admission. Review of the resident's medical record showed: -Did not contain weekly wound assessments or measurements for the weeks of 04/14/24 and 04/21/24; -Did not contain a weekly weight for the week of 09/17/23, 09/24/23, 10/01/23, or 10/08/23 when the resident returned from the hospital on 9/17/23 as directed by facility policy; -Did not contain a weight for March 2024. 7. Review of Resident #251's POS, dated 04/22/24, showed an order for monthly weights. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's medical record between 02/14//24 and 05/01/24 showed staff did not document weights for the month of April. 8. During an interview on 05/02/24 at 9:11 A.M., Restorative Aide K said there is a task that pops up on the Electronic Health Record that reminds us to obtain the weights. The policy says all residents are weighed monthly unless the task pops up sooner. The Restorative Aide is responsible to obtain the weights and document them in the medical record. He/She was not aware some were missing. During an interview on 05/02/24 at 10:23 A.M., the DON said the restorative aide is responsible to obtain and record the monthly weights. He/She said the Restorative Aide has access to the physician orders to see who has orders for weights more often than monthly. The DON said if the weights are not in the medical record, it means they are not done, or the staff forgot to document. He/She said if weights are not documented, residents may experience negative outcomes. 9. Review of the facility's Event Investigation policy, undated, showed staff are instructed to complete a Report of Event Form as soon as possible for falls or person found on a floor with the following information: -Record the date and time of the event; -Description of the event; -Witness name(s) and contact information; -Cognitive status; -Equipment involved; -Observations; -Exact location of an injury and measurement; -Vital signs; -Mental status/Neuro; -Range of motion; -Complaint of pain; -First aid given; -Seen by physician; -Transferred to hospital or emergency room ; -Notification of physician; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-New physician orders; -Responsible Party notification with the date and time of notification; -Actions taken to prevent recurrence; -Nurse completing form and date - Nurse signature with date; -DON and administrator signatures with date; -Follow up 72-hour monitoring initiated in the nurses' notes. 10. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Diagnosis of Alzheimer's; -Required supervision for transfers; -No falls since prior Annual Assessment MDS, dated [DATE]; Review of the resident's medical record, showed staff did not complete a report of event form for the 11/24/23 and 01/22/24 fall. During an interview on 05/01/24 at 10:17 A.M., the DON said when a resident has fall, an Event Report should be filled out and if the fall is unwitnessed, the Event Report should generate a 72-hour neuro check. During an interview on 05/02/24 at 11:12 A.M., the administrator said an Event Report should be put in the computer and a 72-hour check form should be generated if the fall is unwitnessed. 42484 43327

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interview, and record review, facility staff failed to provide appropriate personal hygiene for three residents (Resident #28, #35, and #251) out of 12 sampled dependent residents, The facility census was 44. 1. Review of the facility's Daily Care Needs guidelines, undated, showed after meals staff are diected to wash hands and face of the residents and remove any food particles from resident clothing. 2. Review of Resident #28's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/09/24 showed staff assessed the resident as: -Moderately cognitively impaired; -Dependent on staff for toileting hygiene, showering/bathing, and personal hygiene; -Did not reject care; -Diagnosis of debility, heart disease, lung disease, and dementia. Review of the residents care plan, reviewed 11/27/23, showed staff assessed the resident required assistance for transfers, bathing dressing and grooming daily, may experience bladder incontinence related to muscle weakness and incontinent care to be provided after each incontinent episode. Observation on 04/29/24 at 8:27 P.M., showed the resident with long facial hair, hair disheveled, and an unkempt in appearance. Observation showed the resident had yellow/green residue in the inside of his/her eyes, and wore a tan shirt, red jacket, and blue plaid flannel pants. Observation on 04/30/24 at 10:01 A.M., showed the resident with long facial hair, hair disheveled, an unkempt in appearance, and the resident wore the same outfit from the previous day. Observation on 05/01/24 at 9:21 A.M., showed the resident with long facial hair, hair disheveled, and an unkempt in appearance. During an interview on 04/29/24 at 8:27 P.M., the resident said he/she preferred to be clean shaven and clean looking. 3. Review of Resident #35's Annual MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Dependent on staff for personal hygiene; -Did not reject care; -Diagnosis of dementia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 02/27/24, showed the care plan did not contain facial hair preferences for the resident. Observation on 04/29/24 at 7:37 P.M., showed the resident in bed with long facial hair on his/her chin. Observation on 04/30/24 at 8:01 A.M., showed the resident at the nurse station with long facial hair on his/her chin. Observation on 04/30/24 at 10:22 A.M., showed the resident at the nurse station with long facial hair on his/her chin. Observation on 05/02/24 at 08:28 A.M., showed the resident at the nurse station with long facial hair on his/her chin. During an interview on 05/01/24 at 01:46 P.M., Licensed Practical Nurse (LPN) F said dependent residents should be shaved on bath/shower days and in between if noticed. He/She said any nursing staff can shave residents. During an interview on 05/02/34 at 10:23 A.M., the Director of Nursing (DON) said residents should be shaved. He/She said if the resident refuses care, it should be documented in the nurse notes but would expect staff to make multiple attempts to complete the task. 4. Review of Resident #251's admissions MDS dated [DATE], showed facility staff assessed the resident as follows: - No assessment of cognition or functional ability; -Diagnosis of cancer, hypertension, benign prostatic hyproplasia, dementia, and schizoprehenia. Review of the resident's care plan, dated 04/22/24, showed the resident will have his/her ADL needs met daily as evidenced by maintaining the abilities he/she has now and obtaining assistance for transfers, bathing, toileting, dressing and grooming daily through next review. Observation on 04/30/24 at 10:00 A.M., showed the resident with disheveled hair. The residents clothing had food crumbs on them. Observation on 05/01/24 at 10:13 A.M., showed the resident wore the same outfit from the previous day, hair was disheveled and unkempt in appearance. During an interview on 04/30/24 at 10:06 A.M., the resident said he/she had one bath in a month. He/She said he/she stinks and the staff know he/she needs a bath. During an interview on 05/02/24 at 9:06 A.M. Nurse Aid (NA) J said residents are scheduled to get a shower two times a week or more if needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/02/24 at 9:12 A.M., CNA E said showers are scheduled twice a week and kept in a log book when completed. We have a shower aid. He/She said they offer to shave residents daily as well. During an interview on 05/02/24 at 10:24 A.M., the DON said showers and personal hygiene should be put in a progress note and on shower sheets. The DON said dependent residents should be showered twice a week and independent residents can go whenever they would like. He/She said clothing should be changed daily or after they are soiled. The DON said he/she were responsible but the charge nurses do the daily monitoring. During an interview on 05/02/24 at 11:14 A,M,. the administrator said dependent residents shower should be documented in the point of care feature of our electronic health records and refusals should be documented. Residents should receive one or two showers a week. 42484 43327

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on observation, interview, and record reviews, facility staff failed to ensure residents environment remained safe from hazards when staff failed to safely propel three (Resident #8, #22, and #34) out of 12 sampled residents while in wheelchairs. Facility staff failed to provide two (Resident #14 and #36) out of two sampled residents safe mechanical transfers, and facility staff failed to safely store medications in one residents room (Resident #13). The facility census was 44. 1. Review of the facility's Wheelchair, Use of policy, undated, showed staff were directed to lower footrests and place resident's feet on footrests if used and position feet and legs in good body alignment. 2. Review of Resident #8's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 01/30/24, showed staff assessed the resident as: -Cognitively impaired; -Required set-up assistance for wheelchair locomotion of 50 feet with 2 turns; -Independent wheeling 150 feet in wheelchair. Observation on 04/30/24 at 11:56 P.M., showed Nurse Aide (NA) J propelled the resident into the dining room in his/her wheelchair. The wheelchair did not have foot pedals and the resident's heels touched the floor. 3. Review of Resident #22's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively intact; -Independent with wheelchair locomotion of 50 feet with two turns and 150 feet; -Diagnosis of dementia, muscle weakness and Parkinson's Disease (progressive disease that affects the nerves of the body). Observation on 04/30/24 at 11:47 A.M., showed NA J propelled the resident into the dining room for lunch. The wheelchair did not have foot pedals and the resident's heels touched the floor. 4. Review of Resident #34's Quarterly MDS dated [DATE] showed staff assessed the resident as: -Cognitively intact; -Required set-up assistance for wheelchair locomotion of 50 feet with two turns; -Required supervision assistance for wheelchair locomotion of 150 feet; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis of failure to thrive (weight loss, decreased appetite, and inactivity). Observation on 04/30/24 at 11:49 A.M., showed NA J propelled the resident to the dining room. The wheelchair did not have foot pedals and the bottom of the resident's feet touched the floor. 5. During an interview on 05/02/24 at 9:08 A.M., NA J said residents should never be pushed without putting on the foot pedals. It could cause an injury. During an interview on 05/02/24 at 10:41 A.M., the Director of Nursing (DON)said staff should have foot pedals on before the propel them in a wheelchair. A resident's foot could get caught and injure them. During an interview on 05/02/23 at 11:21 A.M., the administrator said we in-service on wheelchair propulsion once a year and during orientation. There is no exception to pushing a resident in a wheelchair without foot pedals. 6. Review of the facility's Hydraulic Lift policy, undated, showed staff were directed to open the legs of the the lift to the widest point and set brakes when lifting a resident for transfer. 7. Review of Resident #14's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Cognitively impaired; -Required substantial/moderate assistance with sitting to standing, chair/bed-to-chair transfers, toilet transfers, and tub/shower transfers; -Diagnosis of dementia. Observation on 05/01/24 at 2:00 P.M., showed CNA H, CNA E and CNA K entered the room to transfer the resident to the bed. CNA H raised the resident from the wheelchair in the mechanical lift with the mechanical lift legs open. CNA K instructed CNA H to close the mechanical lift legs to push the resident to the bed and lower it. CNA H closed the legs of the lift and pushed the lift over the bed and lowered the resident. CNA H did not leave the mechanical lift legs open when he/she moved the mechanical lift with the resident to the bed. During an interview on 05/01/24 at 2:15 P.M., CNA K said he/she instructed the staff to close the legs of the hoyer because that is how he/she was trained to do it. 8. Review of Resident #36's Annual MDS, dated [DATE], showed facility staff assessed the resident as follows: -Did not contain the resident cognition status; -Total dependence with showering and toilet use. Observation on 05/01/24 at 3:30 P.M., showed CNA H and CNA E transferred the resident from the bed to a wheelchair. CNA H lifted the resident off the bed with the mechanical lift, pushed the resident towards the wheelchair with the mechanical lift legs closed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/24 at 3:40 P.M., CNA H said he/she keeps the legs of the hoyer closed when moving the resident. He/She said aids are in-serviced on mechanical lifts. 9. During an interview on 05/02/24 at 10:45 A.M., the DON said the legs of a lift should remain open during a transfer for stability because if they are not open it becomes a safety issue. During an interview on 05/02/24 at 11:25 A.M., the administrator said the legs of a lift should be open wide for stability of the lift. If the legs are not opened the lift could flip over and injure the resident. 10. Review of the facility's medications, self-administration, self-storage, leave at bedside policy, undated showed: -If a resident expresses a desire to self-administer medication, the interdisciplinary team (IDT) must assess the resident's cognitive, physical, and visual ability to carry out this responsibility; -The mental status and any psychiatric diagnosis must be taken into account; -The Evaluation Assessment to self-administer medications will be used; -When the resident self-administers medication, the resident will be re-assessed on an ongoing basis for continued safety of this practice. The evaluation will be completed annually or with significant change by nursing and reviewed by the IDT to determine if the resident is still capable of self-administering medications; -A physician order will be obtained for each medication to be kept at bedside; -The resident care plan will instruct staff where medication is to be stored and who will document administration of medication. 11. Review of Resident #13's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact with a diagnosis of dementia. Review of the resident's Physician Order Sheet (POS), dated 04/01/24 through 05/31/24, showed the POS did not contain an order for the resident to self-administer any medication. Review of the resident's care plan, showed the care plan did not contain direction for self-administration of medication or self-storage of medication. Observation on 04/29/24 at 7:05 P.M., showed a bottle of nasal spray, inhaler, a medication cup contained two white oval tablets and another medication cup with two large flat tablets. Observation on 05/01/24 at 9:40 A.M., showed a bottle of nasal spray and an inhaler on the overbed table. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/29/24 at 7:05 P.M., the resident said he/she keeps his/her medication in the room all the time in case he/she needs it. He/She said the tablets were tylenol and stomach acid reliever. The resident said sometimes another resident does come into his/her room and gets into his/her stuff. During an interview on 05/02/24 at 8:42 A.M., LPN F said if residents have medication in their room, the resident should be assessed for safety and have an order to keep at bedside. He/She said this resident has an order to self-administer his/her medication. He/She said the facility does have residents who wander into other residents rooms if staff do not catch them ahead of time. During an interview on 05/02/24 at 10:23 A.M., the DON said there should be a physician order to self administer medication with the exception of narcotics which are held by the nurse or CMT. If there is not an order, staff are expected to call the doctor and obtain one. He/She said residents who want to self-administer medication should be screened for comprehension. The DON said if a resident keeps medication at bedside that is not appropriately assessed there is a potential for over or underdosing of the medication, in addition to other residents wandering into the room and taking them. 42484 43327

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40424 Based on interview and record review, facility staff failed to ensure all resident's drug regimens were free from unnecessary drugs when staff failed to ensure gradual dose reductions (GDR) were attempted for psychotropic medications for four (Resident #3, #12, #28, and #36) out of six sampled residents. The facility census was 44. 1. Review of the facility's Drug Review guidelines, undated, showed staff are instructed as follows: -All medication given to each resident will be reviewed on a monthly basis in order to review drug interactions, ensure adherence to stop orders, ensure accuracy in administration, and evaluate medications appropriate to diagnosis. -Problems identified shall be addressed according to need in consultation with physician. -Follow up on problems needs either the Director of Nursing's (DON's) or pharmacist's signature to show that the problem has been addressed. -Develop an interdisciplinary care plan to evaluate behavior pattern in relationship to current medication. -Notify physician of findings and recommendations. Obtain an order for attempts at reduction. 2. Review of Resident #3's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 12/18/23 showed staff assessed the resident as moderately cognitively impaired. Review of the resident's Physician Order Sheet (POS), dated 04/01/24 through 05/01/24, showed an order for Fluoxetine (treats depression) 20 milligram (mg) one tablet once a day. Review of the pharmacy recommendation, dated 03/01/24 showed the resident received Fluoxetine 20 mg daily due for review. Review of the resident's medical record did not contain a completed GDR. 3. Review of Resident #12's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Severely cognitively impaired; -Diagnoses of Alzheimer's Disease, anxiety, psychosis, schizophrenia, and bipolar disease; -Took high-risk medication in the categories of antipsychotic, antianxiety, hypnotic, and antidepressant. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's POS, dated 04/01/24 through 05/01/24, showed the staff are directed to adminster: -Buspirone (treats anxiety) 10 mg, two tablets three times a day; -Quetiapine (an antipsychotic) 50 mg two times a day; -Quetiapine100 mg at bedtime; -Haloperidol lactate solution 5 mg/ milliliter (mL) (treats mood disorders) 2 mls by injection as needed every six hours; -Divalproex Sprinkles (use to treat seizures and bipolar disorder) 125 mg, two tablets three times a day; -Trazodone (treats depression) 50 mg at bedtime; -Fluoxetine (treat depression, obsessive-compulsive disorder; -Phenytoin sodium extended (treats seizures) 100 mg three times a day. Review of the pharmacy recommendation, dated 04/08/24, showed the resident received psychotropic medications due for review to include Divalproex 125 mg, Quetiapine 50 mg twice daily and Quetiapine 100 mg at bedtime, Fluoxetine 60 mg at bedtime, Buspirone 10 mg take two tablets three times daily, and Trazodone 50 mg take one tablet at bedtime. Review of the resident's medical record, showed the record did not contain a completed GDR. 4. Review of Resident #28's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Moderately cognitively impaired; -Diagnoses of dementia and depression; -Took high-risk medication in the category of antidepressant. Review of the resident's POS, dated 04/01/24 through 05/01/24, showed an order for Mirtazapine (an antidepressant) 15 mg, one half tablet at bedtime. Review of the pharmacy recommendation(s), dated 04/08/24, showed the resident received psychotropic medication due for review. Review showed the Mirtazapine tablets 7.5 mg, at bedtime last GDR evaluation 08/02/23. Review of the resident's medical record did not contain a GDR after 08/02/23. 6. Review of Resident #36's Annual MDS, dated [DATE], showed the staff assessed the resident as: -Severely impaired cognition; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnosis of anxiety and depression. Review of the resident's POS, dated 04/01/24 through 05/01/24, showed the following orders: -Trazodone 25 mg at bedtime; -Quetiapine 25 mg at bedtime; -Buspirone 10 mg twice a day; -Sertraline 100 mg once a day; -Clonazepam 0.5 mg as needed twice a day. Review of the pharmacy recommendations, dated 03/01/24, showed the resident received clonazepam as needed. All as needed psychotropic medications must include a duration. Review showed the resident received psychotropic medication Sertraline 100 mg tablet daily, Buspirone 10 mg tablet twice a day, Quetiapine 25 mg at bedtime, Trazodone 25 mg at bedtime, and Clonazepam 0.5 mg twice a day due for review. Review of the pharmacy recommendation, dated 04/08/24, showed the Medication Regime Review (MRR) and GDR request from 3/2024 not addressed. Review of the resident's medical record did not contain a completed GDR. 6. During an interview on 05/02/24 at 10:23 A.M., the Director of Nursing (DON) said when a GDR with recommendations comes in from the pharmacy, the physician should be called about the recommendation, or if the physician is coming in the next day or two, have the physician review the recommendations during the facility visit. The DON said the physician should review and document why they agree or disagree. The DON said the physician should sign the pharmacy recommendation sheet and the nurse should document the recommendation was reviewed and the decision made. During an interview on 05/02/24 at 11:12 A.M., the administrator said pharmacy recommendations should be reviewed by the physician and signed, as well as documentation of reasoning if the physician disagrees.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40424 Based on observation, interview, and record review, facility staff failed to monitor and store medication in a safe and effective manner when staff did not dispose of expired medications and left resident's medication on top of the cart. The facility census was 44. 1. Review of he facility's Storage of Medications policy, undated, showed facility staff were directed as follows: -All medications for residents must be stored at or near the nurse's station in a locked cabinet, a locked medicine room, or one or more locked mobile medications carts; -No discontinued, out dated, or deteriorate drugs or biological may be retained for use. All such drugs must be returned to the issuing Pharmacy or destroyed in accordance with established guidelines. 2. Observation on 05/01/24 at 8:29 A.M., showed the facility medication room contained: -One bottle of extra strength Acetaminophen/diphenhydramine HCl with an expiration date of 08/23; -Two bottles of Therma-M with an expiration date of 03/24; -Five bottles of mucus relief with an expiration date of 04/23; -One bottle of Zinc with an expiration date of 12/23; -Two bottles of Cranberry 450 mg with an expiration date of 02/24. During an interview on 05/01/24 at 8:40 A.M., Certified Medication Technician (CMT) A said all out of date medication should be destroyed. During an interview on 05/02/24 at 8:59 A.M. CMT B said out of date medication should be destroyed. CMT's and nurses are all responsible for monitoring medication storage rooms and carts. During an interview on 05/02/24 at 10:36 A.M., the Director of Nursing (DON) said he/she has CMT's monitor medication storage for out of date or damaged medication. The DON said out of date medications should be destroyed or returned to the pharmacy. The DON said there should be no out of date medication in use or stored in the medication storage room. During an interview on 05/02/24 at 11:25 A.M., the administrator said CMT's and nurses are responsible as a team to monitor medication for out of date or damaged medication. The pharmacy also reviews the medication storage once a month. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 04/30/24 at 08:51 A.M., showed CMT A left an unsecured box with drawers containing residents' medications on top of the medication cart when he/she passed medications to residents. 4. Observation on 05/01/24 08:35 A.M., showed the 100 hall medication cart with a plastic container which contained multiple drawers with resident medication on top unattended. The plastic container could not be locked and was left on top of the medication cart at all times. During an interview on 05/01/24 at 8:40 A.M., CMT A said the plastic box with the drawers has been on the cart since he/she started. He/She was not sure why it was used. During an interview on 05/02/24 at 8:59 A.M. CMT B said CMT's and nurses are all responsible for monitoring medication storage rooms and carts. The plastic box on the top of the cart may be a privacy issue. During an interview on 05/02/24 at 11:25 A.M., the administrator said the unlocked plastic box with drawers on top of the medication cart is a risk to other residents and should be removed for their safety. It was used for regularly used medications and extra storage of meds.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 42484 Based on interview and record review, facility staff failed to designate a person to serve as the Dietary Manager (DM) with the appropriate qualifications. The facility census was 44. 1. Review of facility policies showed staff did not provide a policy related to the qualifications of kitchen staff. 2. Review of the DM's personnel record showed the record did not contain documentation of when the DM assumed the DM role. The record did not contain documentation of previous food service experience or food service management certification. During an interview on 04/30/24 at 08:19 A.M., the DM said he/she was not certified yet, but was currently working on the certification and was about half way done. The Dietary Manager said he/she did not know all of the requirements. During an interview on 05/02/24 at 10:23 A.M., the Director of Nursing (DON) said the Dietary Manager should be certified, and if new to the job at the facility they thought he/she should be certified within four to six months. If the Dietary Manager is not certified, they may not know the guidelines, and residents may not get the right food, or have allergies to some food, and this could cause harm. During an interview on 05/02/24 at 11:12 A.M., the administrator said the Dietary Manager should be certified.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42484 Based on observation, interview, and record review, facility staff failed to use appropriate infection control procedures to prevent the spread of bacteria or other infectious causing contaminants when staff failed to perform appropriate hand hygiene during medication administration for two (Resident #4 and #21) of five sampled residents. The facility staff failed to ensure all employees were screened for Tuberculosis ((TB) a potentially serious infectious bacterial disease that mainly affects the lungs), when staff failed to ensure a two-step purified protein derivative (PPD) (skin test for TB) and annual PPD tests completed and documented as per policy and state law for three employees (Dietary Aide O, Certified Nurses Aide (CNA) E , and Certified Medication Technician (CMT) P) out of 10 sampled employees . The facility census was 44. 1. Review of the facility's Medication, Administration Guidelines, showed the guidelines did not address hand hygiene between administration of medication between one resident and another resident, pouring tablets or pills out from a medication bottle, or eye drops. Review of the facility's Instillation of Eye Medication Guidelines, showed the guidelines did not address infection control during administration of eye medication. Review of the facility's Infection Prevention and Control Program policy, undated, showed the policy did not address hand hygiene between administration of medication between one resident and another resident, pouring tablets or pills out from a medication bottle, or administration of eye drops. 2. Observation on 04/30/24 at 8:51 A.M., showed CMT A did not perform hand hygiene after he/she administered medication to a resident, used a keyboard, prepared medication, lowered a computer screen, and before he/she administered medication to Resident #21. 3. Observation on 04/30/24 at 09:05 A.M., showed CNA A removed Resident #4's Tylenol tablets from a bottle into his/her bare hand, placed the tablets in into a medication cup and administered the medication. 4. Observation on 04/30/24 at 9:09 A.M., showed CMT A did not perform hand hygiene or put on gloves before he/she administered eye drops to Resident #4. 5. During an interview on 05/02/24 at 10:23 A.M., the Director of Nursing (DON) said during medication administration when pouring tablets from a bottle, the tablets should be poured and measured in the cap of the bottle, then placed in the resident's medication cup. When the CMT instills eyedrops, hand hygiene should be completed, and gloves put on before administering the eyedrops. The DON said hand hygiene should be done between every resident. During an interview on 05/02/24 at 11:12 A.M., the administrator said during medication administration, hand hygiene should be done before and after anything is touched, and pills should never be in the bare hands of staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/14/24 at 2:30 P.M., CMT A said hand hygiene should be performed between each resident, and pills should not be poured into bare hands. If eyedrops are administered, staff should perform hand hygiene and put on gloves. CMT A said he/she didn't realize he/she missed performing hand hygiene every time needed, and said staff had a recent in-service on how to put in eyedrops. 6. Review of the facility's policies showed staff did not provide a policy for Catheter Care. 7. Review of Resident #251's Admission Minimum Data Set (MDS), a federally mandated assessment completed by staff, dated 03/27/24, showed staff assessed the resident as follows: -Had an indwelling catheter -Diagnosis of benign prostatic hyperplasia (when the prostate and surrounding tissue expands, can place pressure on the bladder and the urethra, which is the tube that urine passes through. This may cause: difficulty starting to urinate or a frequent need to urinate). 8. Review of Missouri state regulations 19 CSR 20-20.100 Tuberculosis (TB) testing for residents and workers in long-term care facilities showed: -Long-term care facilities shall screen their residents and staff for tuberculosis using the Mantoux method purified protein derivative (PPD) five tuberculin unit test (TST). Each facility shall be responsible for ensuring that all test results are completed, and that documentation is maintained; -Within one month prior to or one week after admission, all residents new to long-term care are required to have the initial test of a two-step TB test; -All employees are required to obtain Mantoux PPD two-step TB test within one month prior to starting employment in the facility. If the initial test is zero to nine millimeters (mm), the second test should be given three weeks after employment begins, unless documentation is provided indicating a PPD test in the past and at least one subsequent annual test within the past two years; -If the resident's or employee's initial test is negative, the second test should be given one to three weeks later. The CDC (Centers for Disease Control) states TB tests should be read 48 to 72 hours after administration; -All long-term care facility residents shall have a documented annual evaluation to rule out signs and symptoms of TB disease; -Employees with an initial zero to nine mm TB two step test shall have one step tuberculin testing annually and the results recorded in a permanent record; -All positive findings shall require a chest X-ray to rule out active pulmonary disease; -Individuals with a positive finding need not have repeat annual chest X-rays. They shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265663	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Nursing & Rehab	1510 Bluff Street Fulton, MO 65251

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's Guideline for screening for tuberculosis in long term care facilities, undated, showed it is important for each facility to have tuberculosis control program in place. This must include the documentation of the tuberculosis status of each resident, staff member, and volunteer of each long-term care facility. Provide a tuberculin skin text (Mantoux, five tuberculin units (TU) of purified protein derivative (PPD) to all employees during pre-employment procedures, unless a previous reaction >10 millimeters (mm) is documented. If the initial skin test results is 0-9mm, a second test should be given at least one week and no more than three weeks after the first test. The results of the second test should be used as the baseline in determining treatment and follow up of these employees. 9. Review of CNA E's personnel file, showed a hire date of 06/09/23. The file did not contain documentation a two-step TB test was completed 10. Review of CMT P's personnel file, showed a hire date of 07/24/23. The file did not contain documentation a two-step TB test was completed 11. Review of Dietary Aide O's personnel file, showed a hire date of 12/12/23. The file did not contain documentation a two-step TB test was completed During an interview on 05/1/24 at 11:47 A.M., the administrator said the charge nurses and MDS Coordinator are responsible for administering and reading the TB tests. He/She said the results were put into a binder. He/she said they have not had a MDS coordinator and could not find the TB binder. He/She said he/she has started a binder and has started over since he/she is overseeing it for the time being. During an interview on 5/1/24 at 12:02 P.M., RN G said the charge nurse and MDS are responsible to administer and read new hire and annual TB tests. He/She said there is a folder where they are logged. He/She said they currently do not have a MDS coordinator and he/she does not know who is in charge of making sure this is completed by the nurses or why it has not been done. 43010 43327